36.13: continued

(l) Rates of payment for emergency services related to the Norplant System are established according to the methodology set forth in 114.1 CMR 36.13(8)(s).

(10) Classifications of Disproportionate Share Hospitals (DSHs) and Payment Adjustments The Medicaid program will assist hospitals who carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment above the rates established under 114.1 CMR 36.13(10) to hospitals which qualify for such an adjustment under any one or more of the following classifications. Medicaid participating hospitals may qualify for adjustments and may receive them at any time throughout the year. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating those adjustments is described in 114.1 CMR 36.13(10). Medicaid payment adjustments for disproportionate share contribute toward funding of allowable uncompensated care costs.

When hospitals apply to participate in the Medicaid program, their eligibility and the amount of their adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications (114.1 CMR 36.13 (10) (a) through (f)). If a hospital's Medicaid contract is terminated, any adjustment will be prorated for the portion of the year during which it had a contract, the remaining funds it would have received will be apportioned to remaining eligible hospitals. This means that some disproportionate share adjustments may require recalculation. Hospitals will be informed if an adjustment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

To qualify for a DSH payment adjustment under any classification within 114.1 CMR 36.13(10), a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. § 1396r-4(d) or qualify for the exemption described at 42 U.S.C. § 1396r-4(d)(2). In addition, to qualify for a disproportionate share payment adjustment under 114.1 CMR 36.13(10) a hospital must have a Medicaid inpatient utilization rate, calculated by dividing Medicaid patient days by total days, of not less than 1%.

Effective October 1, 1995 the total amount of payment adjustments awarded to a particular hospital under 114.1 CMR 36.13(10) will not exceed the costs incurred during the year by the hospital for furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and from uninsured patients, except as provided at 42 U.S.C. § 1396r-4(g).

(a) High Public Payer Hospitals: Disproportionate Share Status under St. 1991, c. 495.

1. Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.10 are eligible for this adjustment.
2. Calculation of Adjustment.
   a. The Division of Medical Assistance will allocate $11.7 million for this payment adjustment.
   b. The Commission will then calculate for eligible hospitals the ratio of their allowable free care charges, as defined in M.G.L. c. 118F, § 2, to total charges, for the period October 1, 1992 through September 30, 1993. The Commission will obtain allowable free care charge data from the Department of Medical Security.
   c. The Commission will then rank the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 36.13(10)(a)2.b.
   d. The Commission will then determine the 75th percentile of the ratios determined in 36.13(10)(a)2.b.
   e. Hospitals who meet or exceed the 75th percentile will qualify for a High Public Payer Hospitals Adjustment. The Commission will multiply each qualifying hospital's FY93 allowable free care charges by the hospital's FY93 cost to charge ratio as of October 1, 1994, as calculated pursuant to 114.1 CMR 36.09 to determine allowable free care costs.
   f. The Commission will then determine the sum of the amounts determined in 114.1 CMR 36.13(10)(a)2.e for all hospitals that qualify for a High Public Payer adjustment.

36.13: continued

g. Each hospital's High Public Payer Hospitals adjustment is equal the amount allocated in 114.1 CMR 36.13(10)(a)2.a. multiplied by the amount determined in 114.1 CMR 36.13(10)(a)2.e. and divided by the amount determined in 114.1 CMR 36.13(10)(a)2.f.

(b) Basic Federally - Mandated Disproportionate Share Adjustment

1. The Division will determine a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Division will use the following data sources in its determination of the federally-mandated Medicaid disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division will determine and use the best alternative data source.

a. The Division will use free care charge data from the Department of Medical Security.

b. The prior year RSC-403 report will be used to determine Medicaid days, total days, Medicaid inpatient net revenues, and total inpatient charges.

c. The hospital's audited financial statements for the prior year will be used to determine the state and/or local cash subsidy.

2. The Division will calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Division will determine such threshold as follows:

a. First, calculate the statewide weighted average Medicaid inpatient utilization rate. This will be determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.

b. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics. This will be determined according to the following formula:

$$\sqrt{\frac{\sum\left(\left(\frac{\text{total days}}{\text{average days}}\right) x \left(\frac{\text{Medicaid days}}{\text{total days}}\right)^2\right)}{N} - \left(\frac{\sum \text{Medicaid days}}{\sum \text{total days}}\right)^2}$$

Where N = number of hospitals, and average days = statewide sum of total days, divided by the number of hospitals.

c. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers will be the threshold Medicaid inpatient utilization rate.

d. The Division will then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.c., then the hospital will be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

3. The Division will then calculate each hospital's low-income utilization rate as follows:

a. First, calculate the Medicaid and subsidy share of gross revenues according to the following formula:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

b. Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

c. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.13(10)(b)3.a. to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.13(10)(b)(3)b. If the low-income utilization rate exceeds 25%, the hospital

36.13: continued

will be eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method.

4. Payment Methodology. The payment under the federally-mandated disproportionate share adjustment requirement will be calculated as follows:

a. For each hospital deemed eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 36.13(10)(b), the Division will divide the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.d. by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.c. The ratio resulting from such division will be the federally-mandated Medicaid disproportionate share ratio.

b. For each hospital deemed eligible for the basic federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division will divide the hospital's low-income utilization rate by 25%. The ratio resulting from such division will be the federally-mandated Medicaid disproportionate share ratio.

c. The Division will then determine, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.13(10)(b)4.a. and 114.1 CMR 36.13(10)(b)4.b.

d. The Division will then calculate a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.13(10)(b)5. by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.13(10)(b)4.c.

e. The Division will then multiply the minimum payment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 36.13(10)(b)4.a. and b. The product of such multiplication will be the payment under the federally-mandated disproportionate share adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

5. The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement will be $200,000 per year. These amounts will be paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.13(10)(b)4.e.

(c) Disproportionate Share Adjustment for Safety Net Providers. The Division shall determine a disproportionate share safety net adjustment factor for all eligible hospitals, using the data and methodology described in 114.1 CMR 36.13(10)(c)1. Through 3..

1. Data Sources. The Division will use free care charge data from the Department of Medical Security, and total charges from the RSC-403. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

2. Eligibility of Hospitals for the Safety Net Provider Adjustment. The disproportionate share adjustment for safety net providers is an additional payment for any hospital which meets the following criteria:

a. is a public hospital or a public service hospital as defined in 114.1 CMR 36.13(2)(j)3.;

b. has a volume of Medicaid and free care charges in FY93, or for any new hospital, in the base year as determined by the Division of Health Care Finance and Policy (formerly the Rate Setting Commission) which is at least 15% of its total charges;

c. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients;

d. has completed an agreement with or is the specificied beneficiary of an agreement with the Division of Medical Assistance for intergovernmental transfer of funds, as defined in federal regulations governing state financial participation as a condition of federal reimbursement, to the Medicaid program for the disproportionate share adjustment for safety net providers;

e. is the subject of an appropriation requiring an intergovernmental transfer.

36.13: continued

3. Payment to Hospitals under the Adjustment for Safety Net Providers. The Division will calculate an adjustment for hospitals which are eligible for the safety net provider adjustment, pursuant to 114.1 CMR 36.13(10)(c)2. This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and shall equal the amount of funds specified in an agreement between the Division of Medical Assistance and relevant governmental unit. The disproportionate share adjustment for safety net providers shall not be in effect for any rate year in which Federal Financial Participation under Title XIX is unavailable for this payment.

(d) Uncompensated Care Disproportionate Share Adjustment Hospitals eligible for this adjustment are those that report "free care costs," as defined by 117 CMR (Department of Medical Security (DMS)) and who are participating in the free care pool administered by the Department of Medical Security pursuant to M.G.L. c. 118F. The payment amounts for eligible hospitals are determined by the Department of Medical Security in accordance with its regulations at 117 CMR 7.00. These payments will be made to eligible hospitals in accordance with Department of Medical Security regulations and the ISA between the Division of Medical Assistance and the Department of Medical Security. Eligible hospitals will receive these payments on a periodic basis during the term of their Medicaid contract with the Division.

(e) Commonhealth Program Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those that provide hospital services pursuant to the Commonwealth program to low-income disabled individuals who are covered by a wholly state-financed program of medical assistance of the Division of Medical Assistance, as defined in regulations of the Division of Medical Assistance at 130 CMR 490.000 and 130 CMR 510.000 through 515.000. The payment amounts for eligible hospitals receiving payments pursuant to the Commonhealth program are determined and paid on a periodic basis by the Division of Medical Assistance in accordance with 130 CMR 490.000 and 130 CMR 501.000 through 515.000.

(f) Medical Security Low-Income Unemployment Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those acute hospitals that provide hospital services to low-income unemployed individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Medical Security, in accordance with regulations of the Department of Medical Security at 117 CMR 9.00. The payment amounts for eligible hospitals participating in the Medical Security plan are determined and paid by the Department of Medical Security in accordance with 117 CMR 9.00 and the ISA between the Department of Medical Security and the Division of Medical Assistance.

(11) Data Sources. The following data sources are used in the development of the base costs per discharge: FY90 Medicaid paid claims file; the FY90 RSC-403 report, as submitted by hospitals to the Division; and the FY90 Merged Casemix/Billing Tapes as accepted by the Division. This data was supplemented by information from each hospital's FY90 year-end Maximum Allowable Cost (MAC) report and information from the intermediaries for the Medicare program, as needed. If a hospital's FY90 RSC-403 was not available, the hospital's FY89 RSC-403 was utilized. The "per review" version of the FY90 MAC report was used, if available. If it was not available, the FY90 "as filed" version was used.

The FY95 casemix index was calculated using the paid claims database for June 1, 1994 through May 31, 1995. This database is maintained by the Commonwealth's Division of Medical Assistance. The fiscal year 1994 RSC-403 cost reports as filed were used to develop rates of payment for organ acquisition, direct medical education, and malpractice costs. Hospital specific capital costs were taken from the FY92 Medicare Cost report (HCFA-2552). Data source used to develop the casemix-adjusted capital cost limit was the FY91 Medicare Cost report (HCFA-2552).

Administrative (AD) days used in the inpatient base calculation are obtained from the FY90 Medicaid claims data file. If the hospital's claims data had zero AD days or the AD days were less than 3% of its total hospital days, the FY90 RSC 404-A fourth quarter reported AD days were used for such hospitals.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

TN 96-11
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 10: MGL c.151A §14G

directed to file with the chairman of said committees an updated report detailing the most recently available statement of the actual balance then credited to the commonwealth's account in the Unemployment Insurance Trust Fund together with a revised statement of the actual balance then projected to be credited to the commonwealth's account during such year.

History—

Amended by 1990, 177, §§ 260—262, approved, with emergency preamble, Aug 7, 1990.

Editorial Note—

The 1990 amendment, by § 260, substituted "commissioner" for "director", in each instance it appears, by § 261, substituted "*commissioner's*" for "director's", in two places, and by § 262, substituted "Unemployment Trust Fund" for "unemployment trust fund", in two places, and substituted "Unemployment Insurance Trust Fund" for "unemployment insurance trust fund".

Acts 1992, ch. 118, §§ 53, 54, entitled "An Act relative to restoring solvency to the unemployment insurance trust fund" which was approved, with emergency preamble, July 14, 1992, provide as follows:

SECTION 53. In addition to the information required to be provided in section fourteen F of chapter one hundred and fifty-one A of the General Laws, the commissioner of the department of employment and training shall include in each quarterly report a five year projection, using applicable schedules, for the private contributory system which indicates for each calendar year estimated contributions, benefit payments, trust fund balance, total estimated interest owed to the federal government as of September thirtieth of the calendar year, interest to be collected by employers through the surcharge imposed under section fourteen J of said chapter one hundred and fifty-one A on an accrued basis, and the aggregate dollar amount of FUTA employer credit reduction that will be applicable in the calendar year. Such quarterly reports shall include the economic assumptions on which the projections are based including the total covered payroll, taxable payroll, covered employment, the effective tax rate on taxable wages for the applicable schedule which shall include the solvency assessment, the taxable wage proportion, the total unemployment rate, and the total insured unemployment rate. The quarterly reports shall be audited by a private, independent organization by December thirty-first of each year.

SECTION 54. The report of the commissioner of the department of employment and training provided each October fifteenth shall include a recommendation regarding the amount of contributions necessary for the succeeding calendar year to achieve a positive trust fund balance, at reasonable increments, by December thirty-first, nineteen hundred and ninety-five and ninety-six and shall include a statement, if applicable, that the total contributions for the succeeding calendar year may exceed one and seventy-five hundredths percent of total wages in such year and any recommendations to prevent the same.

§ 14G. Unemployment Health Insurance Contribution; Medical Security Contribution; Employees Excluded; Deductions Allowed; Computation of Contribution; Rate Review Board; Penalties; Hearing and Appeal; Notice of Eligibility for Health Insurance Coverage.

(a) Each employer, except those employers who employ five or fewer employees, subject to the provisions of section fourteen, fourteen A, or fourteen C shall pay, in the same manner and at the same times as the commissioner prescribes for the contribution required by section fourteen, an unemployment health insurance contribution computed by multiplying the wages paid its employees by twelve hundredths of one per cent.

(b) Each employer, except those employers who employ five or fewer employees, subject to the provisions of section fourteen, fourteen A, or fourteen C shall pay, in the same manner and at the same times as the commissioner prescribes for the contribution required by section fourteen,

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a medical security contribution for each employee computed by multiplying the wages paid each employee by twelve per cent. For the purposes of this section, "employee" shall not include the following employees of any employer: (i) any employee who has been employed by such employer for fewer than ninety days from date of hire, (ii) any employee who normally works for fewer than thirty hours per week; provided, however, that any head of household who has dependent children living at home and is working at least twenty hours per week or any employee having worked at least five hundred and twenty hours in the prior six months shall be considered to be an employee for the purposes of this section; (iii) any employee who is hired to perform a service for a period of less than five months; (iv) any seasonal agricultural employee, who for the purposes of this section shall be defined as an individual who is employed in agricultural employment of a seasonal or other temporary nature; and (v) any employee who is covered by a group or nongroup health benefit plan which is financed without any participation by the employer, who is enrolled in the medicare program, or who is covered by a government operated medical assistance program; and provided, further, that any employee covered by a health insurance plan established pursuant to section nine of chapter one hundred and eighteen F shall be considered to be an employee for the purposes of this section. Each employee as defined in section one shall be presumed to be an employee as included in this section unless the employer certifies to the commissioner, in such form and manner as the commissioner may require, that such employee should not be included under the provisions of this section. Each employer may require any employee to verify his health insurance status pursuant to such rules and regulations as the director shall promulgate. No employer may require an applicant for employment to disclose his health insurance status or that of his spouse, dependents, or other family members. In no case may an employer discriminate against such applicant on the basis of said applicant's health insurance status. Any person aggrieved by a violation of the preceding two sentences may institute within three years of such violation a civil action for injunctive relief and any damages thereby incurred. Any employer found to be in violation pursuant to the action of the aggrieved person shall reimburse such reasonable attorney fees and court costs incurred in the protection of rights granted as shall be determined by the court.

(c) An employer may deduct from the amount owed for each employee under subsection (b) its average expenses per employee for providing health insurance coverage or other health care benefits for its employees, allowable for the current quarter by the Internal Revenue Service as a deductible business expense; provided, however, that any nonincorporated employer may deduct from the amount owed for each employee under subsection (b) its average expenses per employee for providing health insurance coverage or other health care benefits for its employees as reported and allowed pursuant to rules and regulations promulgated by the commissioner; and provided, further, that such deduction for any employer shall not reduce the contribution for any employee below zero.

(d) Such unemployment health insurance contribution and such medical

security contribution shall be paid to the commissioner in accordance with the procedures prescribed by the commissioner. The receipts from such contributions shall not be deposited in the state Unemployment Compensation Fund, but shall be impressed with a trust and dedicated, through the state treasurer as trustee, to the Medical Security Trust Fund established in chapter one hundred and eighteen F. Prior to the depositing of the receipts, the commissioner may deduct all administrative costs incurred as a result of this section, including an amount as determined by the United States secretary of labor in accordance with federal cost rules, but in no calendar year may such deduction exceed five per cent of the amounts collected pursuant to this section.

[No change through subsection (g).]

(h) There shall be a rate review board composed of the secretary for administration and finance or his designee, the secretary of human services or his designee, and the secretary of economic affairs or his designee. Said board shall determine the rate of health insurance inflation for the previous year to be applied to the medical security wage base for the subsequent calendar year and shall certify said rate to the commissioner on or before November thirtieth of the year preceding the year to which the medical security wage base is to be applied. This inflation rate shall be the average percentage increase in premiums for accident and sickness insurance policies issued in the commonwealth during the then current calendar year over premiums for accident and sickness insurance policies issued in the commonwealth during the then previous calendar year.

[No change in the second paragraph of subsection (h).]

(i) Any employer who fails to file any report or form as required by this section shall pay a penalty equal to ten percent of the contribution due under this section; provided, however, that the penalty assessed shall not exceed one hundred dollars nor be less than twenty-five dollars for each such failure to file, in addition to restitution for any amounts owed to the Medical Security Trust Fund as a result of such failure to make a correct contribution.

Any penalties collected pursuant to this section shall be deposited in the health insurance hardship trust fund established by chapter one hundred and eighteen F.

Any employer, in accordance with rules and regulations promulgated by the commissioner, who relies in good faith on statements by employees relative to their health insurance status shall not be liable for any penalty or restitution for failure to comply with the provisions of this section caused by misstatements of such employees.

Any contribution under this section shall be allowable as a business expense.

(j) Any employer notified of a determination of the commissioner that it is subject to the provisions of subsection (a) or subsection (b), or notified of a determination of the commissioner that an individual is an employee for the purposes of subsection (b) and subsection (c), may request a hearing on such determination. The request for hearing shall be filed within ten days after mailing of the notice of the determination. If a

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hearing is requested, the commissioner shall give the employer a reasonable opportunity for a fair hearing before an impartial hearing officer designated by the commissioner. The conduct of such hearing shall be in accordance with the procedures prescribed by subsection (b) of section thirty-nine. Any employer aggrieved by the decision following such hearing may appeal such decision. Such appeal shall be in accordance with the procedures prescribed by sections forty to forty-two, inclusive. Unless action is taken under section forty, the decision of the commissioner shall be final on all questions of fact and law.

(k) The department shall provide written information to every individual who is eligible for unemployment benefits, including extended benefits under section thirty A or extended unemployment compensation benefits under the federal Emergency Unemployment Compensation Act of 1991 or any other federal act, that such individual may be eligible for health insurance coverage pursuant to this section and the provisions of section nine of chapter one hundred and eighteen F. In addition, the department shall post in their local offices a clear and conspicuous notice advising such individuals of their rights under this section, which notice shall be in English, Spanish, and any other language which the department determines appropriate for the area office in which the notice is posted. The department of medical security shall provide the department with such information and notice.

History—

Amended by 1990, 177, §§ 263, 264, approved, with emergency preamble, Aug 7, 1990; 1992, 26, § 15, approved, with emergency preamble, April 27, 1992 (see 1992 note below); 1993, 263, §§ 10, 11, approved, with emergency preamble, Nov 24, 1993.

Editorial Note—

Section 79 of the inserting act (1988, 23) provides as follows:

Section 79. Except as otherwise provided, the provisions of subsection (a) of section fourteen G of chapter one hundred and fifty-one A of the General Laws shall apply to wages paid on or after January first, nineteen hundred and ninety. The provisions of subsections (b) and (c) of said section fourteen G shall apply to wages paid on or after August first, nineteen hundred and ninety-six. (Amended by 1991, 138, § 222, approved July 10, 1991, by § 393, effective July 1, 1991; 1994, 274, § 3, approved, with emergency preamble, Dec 30, 1994; 1995, 239, § 4, approved, with emergency premable, Nov 22, 1995.)

The 1990 amendment, by § 263, substituted "commissioner" for "director", wherever appearing in this section (with the exception of its appearance in the fourth sentence of subsection (b)), and by § 264, in the second sentence of subsection (d), substituted "Unemployment Compensation Fund" for "unemployment compensation fund", and in the second sentence of subsection (d) and in subsection (i), substituted "Medical Security Trust Fund" for "medical security trust fund".

The 1992 amendment added subsection (k).

The 1993 amendment, by § 10, in subsection (i), substituted the first paragraph for one which read: "Any employer who fails to comply with the provisions of this section shall pay a penalty of not less than thirty-five dollars or five dollars for each employee, whichever is greater, for every day during which the failure continues, in addition to restitution for any amounts owed to the Medical Security Trust Fund as a result of such failure to make a correct contribution."; and by § 11, in subsection (k), substituted the last sentence for one which read: "In devising such information and notice the department shall seek assistance from the department of medical security."

Total Client-Service Library® References—

16 Mass Jur, Employment and Labor Relations §§ 17:67, 69, 70, 71, 104, 114, 125.

GL c 151A § 1

(g) "Department", the division of employment and training within the department of labor and workforce development.

GL c 151A § 14G

SECTION 451. Section 14G of chapter 151A of the General Laws, as appearing in the 1994 Official Edition, is hereby amended by striking out, in line 67, the words "chapter one hundred and eighteen F" and inserting in place thereof the words:- subsection (l).

GL c 151A § 14G

SECTION 452. The second paragraph of subsection (h) of said section of said chapter 151A, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:- On or before November thirtieth of each year, the department shall certify to the board the estimated costs for the subsequent year of health insurance coverage provided for individuals and their families who (1) are eligible for the health insurance program established by subsection (l) for individuals receiving unemployment compensation and or (2) are eligible for the health insurance program established by section nineteen of chapter one hundred and eighteen G.

GL c 151A § 14G

SECTION 453. Subsection (i) of said section 14G of said chapter 151A, as so appearing, is hereby amended by striking out the second paragraph.

GL c 151A § 14G

SECTION 454. Subsection (k) of said section 14G of said chapter 151A, as so appearing, is hereby amended by striking out, in lines 187 and 188, the words "and the provisions of section nine of chapter one hundred and eighteen F,- by striking out, the last sentence.

GL c 151A § 14G

SECTION 455. Said section 14G of said chapter 151A, as so appearing, is hereby further amended by adding the following two subsections:- (l) The department shall establish and may operate a health insurance program for the benefit of persons who meet both of the following criteria: (1) the person is receiving or is eligible to receive unemployment compensation benefits under this chapter, including extended benefits under the provisions of section thirty A or extended unemployment compensation benefits, hereinafter referred to as EUC benefits, under the federal Emergency Unemployment Compensation Act of 1991 or any other federal act; and (2) the gross income of the person and the person's spouse, if any, including any income received from unemployment benefits, extended benefits or EUC benefits as provided in clause (1), is less than or equal to four times the non-farm poverty guidelines of the United States Office Of Management and Budget. The health insurance program administered by the department shall consist of the following options: a buy-in option called the continuation plan under which the department shall subsidize a

GL c 151A § 14G

qualified person's continued enrollment in the health insurance plan to which they belonged at the time of, or prior to, applying for unemployment compensation benefits, including persons whose continued eligibility for said enrollment is based on the federal COBRA law, so-called; as well as an option called the direct coverage plan which shall consist of a limited plan of health care services and benefits to be administered by the department. To qualify for benefits under this section, the department shall require that applicants maintain continued enrollment in the health insurance plan in which they were enrolled prior to applying for unemployment compensation benefits, or as permitted by the federal COBRA law. Persons so qualified shall be ineligible for enrollment in the direct coverage plan and the department shall subsidize enrollees' continued health insurance plan by reimbursing said enrollees for a portion of their premium cost in accordance with the department's benefits schedule. Persons unable to qualify for COBRA benefits, so-called, due to lack of access to prior health insurance coverage through their former employer or their spouse's employer or a hardship determined by the department, shall be eligible for the direct coverage plan pursuant to the eligibility requirements of this section. The department shall establish a schedule of copayments and deductibles within the direct coverage plan which shall promote the cost-effective use of services by participants in the program. The department shall establish procedures for the calculation of the gross income of an applicant or the applicant's spouse, if any, for the purposes of determining eligibility under a health insurance plan established under this section. Such procedures shall provide that in determining the income of the applicant or the applicant's spouse, if any, the department shall examine the gross income of the applicant and the applicant's spouse, if any, in the six months prior to application, and a projection of the gross income of the applicant and the applicant's spouse, if any, including a calculation of the maximum benefits payable to the applicant and the applicant's spouse, if any, from unemployment benefits, extended benefits or EUC benefits, for the six months after application. Such procedures shall also make provisions for the redetermination of eligibility for an enrollee or the enrollee's family. The department shall establish grievance procedures under which any decision, action or inaction of the department which directly affects an enrollee or the enrollee's family, and is related to the receipt of benefits under this section can be revived. The department shall establish appeal procedures under

GL c 151A § 14G

which an applicant may appeal a denial of benefits in whole or in part or may appeal a determination of income, or under which an enrollee may appeal termination from the program. For the purposes of this section the words "family members" of the applicant or enrollee shall include the applicant or enrollee's spouse, and any legal dependents. The department shall prepare reports on the status of the program established in this section, and submit such reports annually on the first Wednesday in January, April, July, and October to the joint committee on health care and the house and senate committees on ways and means. Such report shall include, but not be limited to, the number of enrollees in the program for the previous quarter, the amount of benefits paid out in the previous quarter, and the end of quarter balance in the Medical Security Trust Fund established in subsection (m). The commissioner is hereby authorized to delegate, by means of an interagency service agreement, to another state agency the authority to manage and administer the health insurance program established by this subsection. (m) There is hereby established a medical security contribution trust fund, which shall be administered and expended by the department without further appropriation. Said trust fund shall consist of employer unemployment health insurance contributions required by subsection (a) and premiums paid by enrollees. Said fund shall be used exclusively for the payments of premiums for health insurance plans provided to persons receiving unemployment compensation. The commissioner shall from time to time requisition from said trust fund such amounts as he deems necessary to meet the current obligations of the department and estimated obligations for a reasonable future period.

GL c 151A § 29E

SECTION 456. Chapter 151A of the General Laws is hereby further amended by inserting after section 29D the following new section:-

Section 29E. (a) The deputy director shall notify in writing each individual who files a new initial claim for benefits under this chapter, at the time of filing such claim, that: (1) any payments of unemployment compensation as defined in section 85(b) of the Internal Revenue Code received under this chapter are subject to federal and state income tax; (2) receipt of such payments may require the individual to make quarterly estimated payments of federal and state income tax; and (3) the individual may elect, in accordance with the procedures prescribed by the commissioner, to have federal and state income tax deducted and withheld from such payments of unemployment compensation.

Attachment 4.19A (1)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

TN 96-11
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 11: 105 CMR 160.000